Memorial Healthcare | Gastroenterology

Patient Health History

Patient Name_________________________________DOB_____________Age___________

Referring Physician_____________________

Pharmacy_______________________
Pharmacy Location/Phone___________________
____

Previous Surgeries

Date: *Surgery*

_________ ____
_________ ____
_________ ____
_________ ____
_________ ____
_________ ____

Personal History

Caffeine Use: Coffee, Tea, Soda, Energy drinks (circle). Amount/day_________
Do you smoke: Y/N How Much__________
Do you have a history of smoking: Y/N How Long _________
Do you drink alcohol: Y/N How much_______ How often____________
Any use of Illicit (illegal) drugs: Y/N Present ____ Past ____
Tattoos: Y/N
Any Piercings (including ears): Y/N
Medical marijuana card: Y/N

Allergies

Latex Allergy Y/N

Allergy Reaction

___________________________ ____________________________________
___________________________ ____________________________________
___________________________ ____________________________________
___________________________ ____________________________________

Family History

Age **Diseases** **Cause of Death**

Mother
Father
Brothers
Sisters
Children

Family history of colon cancer Y/N
Who__________________________

Family history of colon polyps Y/N
Who____________________________

Patient Name_________________________________

Medications (including all over the counter, vitamins and supplements)

Medication **Dose** **Directions**

____
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____

Previous Testing

Test **Date** **Result**

ERCP____
Barium Enema____
Upper GI X-ray____
EGD (upper scope)____
Colonoscopy (lower scope) ____
Ultrasound of the abdomen____
CAT scan of abdomen/pelvis____
MRI of abdomen/pelvis____
Stool for Blood____
TB test____

Recent Blood Work Y/N

Where____________________________

If you have had any testing at any other hospital other than Memorial Healthcare please list the names so we can obtain those records before your appointment.

____
____
____

Review of Symptoms

Acute GI Symptoms

Black, Tarry Stools Y/N
Bloating Y/N
Red Blood in stools Y/N
Constipation Y/N
Diarrhea Y/N
How often__________
Difficulty swallowing Y/N
Gallstones Y/N
Gas Y/N
Heartburn Y/N
How often__________
Jaundice Y/N
Mucus in stool Y/N
Milk intolerance Y/N
Nausea Y/N
Stomach pain Y/N
Where_____________
Vomiting Y/N
Vomiting blood Y/N
Other
Describe___________
____

General

Chills Y/N
Fatigue Y/N
Fever Y/N
Flushing Y/N
Loss of appetite Y/N
Night sweats Y/N
Weight loss Y/N

Skin

Hives Y/N
Itching Y/N
Rash Y/N

Eyes

Blurred vision Y/N
Cataracts Y/N
Corrective Lens Y/N
Double vision Y/N
Glaucoma Y/N

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Respiratory

Ear, Nose and Throat

Dizziness Y/N
Earache/pain Y/N
Nose bleeds Y/N
Runny nose-chronic Y/N
Seasonal allergies Y/N
Sore throat-chronic Y/N
Ulcers in mouth/cancer Y/N

Gastrointestinal

Acid Reflux Y/N
Colon cancer Y/N
Colon polyps Y/N
Diverticulosis/it is Y/N
Hiatal Hernia Y/N
Irritable bowel Y/N
Liver disease Y/N
Pancreatitis Y/N
Stomach ulcers Y/N
Ulcerative Colitis Y/N
Crohn's Disease Y/N

Genitourinary

Burning with urination Y/N
Hard to start urine Y/N
Incontinence Y/N
Kidney failure Y/N
Kidney stones Y/N
Passing blood in urine Y/N

Cardiovascular

A.Fib Y/N
Ankle swelling Y/N
Chest pain/Angina Y/N
Congestive heart failure Y/N
Endocarditis Y/N
High blood pressure Y/N
High Cholesterol Y/N
High triglycerides Y/N
Irregular heart beat Y/N
Mitral valve prolapse Y/N
Pain in legs Y/N
Stroke Y/N

Females

Asthma Y/N
Chronis cough Y/N
Coughing up blood Y/N
Chronic hoarse voice Y/N
Shortness of breath Y/N
Tuberculosis Y/N
Wheezing Y/N
Other____________________

Endocrine

Diabetes Y/N
Thyroid disease Y/N

Hematology/lymph

Anemia Y/N
Bleeding disorder Y/N
Bruise easily Y/N
Swollen lymph nodes Y/N

Musculoskeletal

Arthritis Y/N
Back pain Y/N
Fibromyalgia Y/N
Joint pains Y/N
Joint swelling Y/N
Lupus Y/N
Neck pain Y/N

Neurologic

Fainting/passing out Y/N
Loss of memory Y/N
Muscle weakness Y/N
Paralysis Y/N
Headaches/migraines Y/N
Seizures Y/N
Slurred speech Y/N
Tingling in hands Y/N
Tingling in feet Y/N

Psychological

Considered suicide Y/N When_____________
Hallucinations Y/N
Hard to concentrate Y/N
Often feel depressed Y/N
Often feel lonely Y/N
Tendency to worry Y/N
Unable to sleep Y/N

Date of Last Pap_______________
Last menstrual cycle____________
Last mammogram______________

Males

Hernia Y/N
Where______________
Prostate problems Y/N